DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 26 1945

Registration District No. 377

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10721

Primary Registration District No. 3063

Registrar's No. 736

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis Co. Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 hours - 15 min (Specify whether
In this community 1½ yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Overland, 91
(If outside city or town limits, write "RURAL")

(d) Street No. 10234 Niblic Dr. 13
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MARILYN TIEHES

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race white

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 10 (Month) 13 (Day) 35 (Year)

8. AGE:

Years	Months	Days	If less than one day
9	5	4	hr. min.

9. Birthplace Perryville (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Student

11. Industry or business —

FATHER
12. Name Vallie Tiehes
13. Birthplace Perryville (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Euphemia Estel
15. Birthplace Perryville (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Vallie Tiehes - father

(b) Address 10234 Niblic Dr., Overland, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-45 (Month) (Day) (Year)

(c) Place: burial or cremation Perryville, Mo. Motor

18. (a) Signature of funeral director Baumann Bros Inc.

(b) Address 2504 Woodson Rd - Overland, Mo.

19. (a) MAR 21 1945 (Date received local registrar) (b) E. G. McGowan, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 3 day 17
year 1945 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from 3-17 (11:15 a.m.) 1945, to 3-17 (3:30 PM) 1945; that I last saw her alive on 3-17, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Burns - 2nd & 3rd degree	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature W. H. Lewin (M. D. or other)

Address St. L. Co. Hosp. 601 Brentwood Date signed 3-17-45

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Oscar F. Muller

Licensed Embalmer No. 3039

P. O. Address Overland Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10711

Registration District No. 317 Primary Registration District No. 8063 Registrar's No. 736

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Marilyn Tiehes
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive or dead years
7. Birth date of deceased Oct 13 (Month) (Day) (Year)
8. AGE: Years 9 Months 5 Days 4 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Day 7 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to 81-15	
Due to 1 35	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 2 mo x 3rd degree burns of low back Abrasions
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence 3/17/45
(c) Where did injury occur? St Louis County, Overland, Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? no (e) Means of injury Fire
23. Signature W. H. Lewin M.D. (M. D. or other)
Address St Louis County Hospital Date signed 6/25/45

SUPPLEMENTARY

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD